Care South

Templeman House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This was an unannounced comprehensive inspection carried out on 18 and 20 March 2015. Templeman House provides residential care for up to 41 people, some of whom may be living with dementia. There were 36 people living in the home during our inspection.

Accommodation is arranged over three floors and there is a passenger lift to assist people to get to each floor.

At the time of this inspection the home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected Templeman House in February 2014. At that inspection we found the service was meeting all the essential standards that we assessed.

At this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations

Summary of findings

2010 which correspond to Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The manager told us that 12 people at the home was subject to the Deprivation of Liberty Safeguards (DoLS). They also explained that they had applied for DoLS for all of the people who lived in the home. However, some staff lacked understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were unable to tell us which person had been deprived of their liberty.

People were not fully protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines safely.

There were not always enough staff to meet people's needs and staff did not receive support meetings in accordance with the provider's policy.

Risks to people were not always assessed, monitored and planned for to make sure people were consistently safe from harm. People's care plans and monitoring records were not consistently maintained and we could not be sure they accurately reflected the care and support people needed or that had been provided to people.

Some communal areas of the home were not clean and furnishings were worn and stained.

Staff were kind and caring but did not always respect people's dignity and privacy.

The governance at the home was not always effective because record keeping was inconsistent and shortfalls identified in audits had not all been addressed to make sure the service continually improved. People, relatives and staff were not routinely consulted and did not have the opportunity to influence change at the home.

Staff were recruited safely and were provided with regular training so they had the skills and knowledge to be able to meet people's needs.

People were supported to maintain their health and had access to healthcare professionals when required.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Improvements were needed to make sure the service was consistently safe. Risks to people were not always managed and planned for so that people were kept safe.

Medicines were not managed safely because some medicines were not signed for and some people did not have as needed medicine plans in place.

People told us they felt safe and staff knew how to recognise and report any allegations of abuse.

There were not enough staff to meet people's needs and there was a reliance on staff from an agency. Staff were recruited safely.

Is the service effective?

Requires improvement

The service was effective but some improvements were needed.

People's rights were not effectively protected because staff did not understand the implications of the Mental Capacity Act 2005.

People were offered a choice of food. Hot and cold drinks were offered regularly throughout the day and people were assisted to eat and drink when required.

Staff had training to carry out their roles.

People accessed the services of healthcare professionals as appropriate.

The design and décor of the home did not always take into account the needs of people living with dementia.

Is the service caring?

Requires improvement

The home was caring but improvements were required to ensure people's privacy and dignity were upheld. People and relatives told us that staff were kind, caring and compassionate.

Staff were aware of people's preferences and the way they liked to be cared for.

Is the service responsive?

Requires improvement

The service was responsive but some improvements were needed.

People's needs were not always assessed and some care was not always planned and delivered to meet their needs.

People were supported to take part in activities that they enjoyed. People said their visitors were always made welcome.

There was a complaints procedure in place and people knew how to complain.

Summary of findings

Is the service well-led?

Some aspects of the service were well-led but improvements were needed.

There were shortfalls in the care plans and record keeping for people and this meant we could not be sure of the care they received.

There were systems in place to monitor the safety and quality of the service but shortfalls had not been actioned. The provider told us an action plan was in place but the shortfalls had not yet been addressed.

Observations and feedback from people, staff and professionals showed us the service had an open culture.

Feedback was not regularly sought from people, staff and relatives.

Requires improvement

Templeman House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 and 20 March 2015 and was unannounced. There was one inspector and a specialist advisor in the inspection team. We met and spoke with eight people living in the home, five relatives and two GPs. Because some people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the registered manager, the provider's service manager, three care staff and two ancillary staff.

We looked at six people's care and support records, and care monitoring records, five people's medicine administration records and a selection of documents about how the service was managed. These included four staff training files, four staff recruitment files, infection control and medicine audits, meeting minutes, training records, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included information about incidents the provider had notified us of. We also contacted commissioners to obtain their views.

We did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they planned to make. This was because we brought forward this inspection because we received some concerns.

Requires improvement

Is the service safe?

Our findings

We received contradictory feedback about staffing levels in the home. Some people told us there were enough staff, however, some others disagreed. One person said, "I think there are enough staff" but another person told us, "It really depends; sometimes the home can be short staffed. One member of staff told us that the home had a reliance on agency staff and that this impacted on the home as agency staff did not always know people's needs well. Another member of staff told us that there were not enough staff and the care that people received was very task orientated. They said, "There is a lack of staff and a lack of support." Following the inspection the service manager for the provider told us they would review the staffing levels at the home.

We carried out observations on each of the floors to assess if people had their needs met and received safe care. We saw that generally, people's needs were met. However, during the lunchtime period; people were not always supported appropriately. For example, people who ate in one of the smaller living rooms were not offered clothes protectors. One person dropped food over their clothes and became distressed as there were not any staff to respond to them. At this point we intervened and notified the manager who assisted the person. There were no staff present in the living room, for long periods of the lunchtime service despite two people whose care plans detailed that they required prompting during mealtimes.

These staffing shortfalls were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now to Regulation 18(1) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's risks were not always appropriately managed. One person did not have a care plan or risk assessments in place. We raised this with the manager who told us that the person had come to live in the home at the end of March 2015, but was subsequently admitted to hospital and had only recently returned to the home the night before our inspection. Other risk assessments had not been reviewed for a number of months. For example, one person's risk assessments had not been reviewed since June 2014. This meant that this person was at risk of unsafe or inappropriate care.

Care was not always planned and delivered in a way which ensured people's welfare and safety.

People's care plans did not state whether people had the capacity to use call bells. We saw that there were no call bells in the main lounge of the home and one of the ground floor toilets. In other rooms we saw that call bells were secured to the walls which meant they were out of reach of people to use should they require assistance. One person told us, "I would have to call out if I needed help because I can't move. We discussed this with the registered manager who found more call bells during our inspection.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9 (1)(3)(a)(b) and 12 (2)(a)(b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at information in medication administration records and care notes for five people who lived at the service. Medicine administration records contained an up-to-date photograph and details of any known allergies. We saw that most medicines had been signed for when given, however we saw omissions on the MAR for one person on several occasions for a type of cream that was required to be applied twice daily. Another person had been prescribed pain relief; however this was not recorded on the person's MAR, which meant that they were at risk of not receiving the medicine.

In care plans we looked at, we saw most had guidance about when a person required prn (as required) medicines. This gave information about what the medicine was for, indications for taking the medicine and the dose. However we looked at two care plans and associated MAR and found that there were no prn care plans in place. There were no pain assessment charts in place for people who may not be able to verbally tell staff if they were experiencing pain. A pain care plan is recommended because this provides the individual signs people can display when they are in pain.

Appropriate arrangements were not in place in relation to the recording of medicine. These shortfalls in the management of medicines were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 12 (2)(g)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service safe?

General medicines were stored appropriately in secure lockable cupboards. However we found that some creams were left in people's bedrooms, which may have posed a risk. We discussed this with the manager who arranged for these to be stored securely. Some medicines required storage at a low temperature. The provider had a fridge to keep these medicines at the correct temperature. Staff were conducting regular temperature checks to ensure the medicines were kept at the correct temperature. There were appropriate systems in place for the management of controlled drugs.

People who lived in the home were not always safe because there were a number of cleanliness shortfalls that compromised the control of infection within the home. We saw that a number of chair covers in the communal areas of the home were stained and/or soiled. Some slings in the home were also soiled. We discussed the cleaning of communal furniture with staff who told us that chair covers and slings were cleaned but there was no system in place and it was not recorded. We saw that some pressure area cushions in the home had worn down to the threads which meant they were impossible to clean effectively. We saw that the furniture in some people's rooms was broken and/or worn down.

Infection control checks had been carried out by staff which had identified some areas for attention. However these were ineffective as improvements identified by the audit had not been completed. For example, we saw that the report dated September 2014 which identified some of the shortfalls mentioned above, such as communal furniture that required replacing.

These shortfalls are breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now Regulation 12 (2)(h)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home's housekeeping staff carried out daily cleaning schedules, and deep cleaning of rooms which were taking place during the inspection. We saw that the homes laundry room was segregated into clean and dirty areas in accordance with guidance. We looked in the home's kitchen, which appeared clean and well organised. We looked at the kitchen cleaning schedules that were mostly complete. The service held a maximum five star rating for food hygiene from Environmental Health, which is the highest rating that can be attained.

Legionella testing was regularly taking place. Legionella are water-borne bacteria that can cause serious illness. Health and safety regulations require persons responsible for premises to identify, assess, manage and prevent and control risks, and to keep the correct records. We saw that there were processes in place to manage risk in connection with the operation of the home. These covered all areas of the home management, such as gas safety, lift servicing, fire risk assessments and the control of hazardous substances.

The provider's staff recruitment procedures minimised risks to people who lived at the home. Application forms contained information about the applicant's full employment history and qualifications. Each staff file contained two written references one of which had been provided by the applicant's previous employer. We saw applicants had not been offered employment until satisfactory references had been received and a satisfactory check had been received from the Disclosure and Barring Service (DBS).

People we spoke with said they felt safe. They told us they were confident the provider did everything possible to protect them from harm. They told us they could speak with the manager if they were worried about anything and they were confident their concerns would be taken seriously and acted upon. One person told us, "Oh yes I feel perfectly safe." Another person told us, "I feel relaxed and safe here." A visitor told us that since their relative had moved into the home they received excellent support from staff. They told us that they visited the home on a regular basis they felt that their relative was kept safe. They described the home as, "relaxed but also professional."

Staff told us they had received training and knew what actions to take to protect people they thought might be at risk of harm or abuse. All staff were familiar with policies and knew who they should report concerns to both internally and externally. Staff said they were confident any concerns would be acted upon. We saw information about protecting people from abuse was readily available for staff and visitors to access so they would know what actions to take.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals.

Mental capacity assessments were not always carried out and when they were they were not decision specific. For example, one person was recorded as 'had not got capacity'; however there was no mental capacity assessments or best interest decisions recorded in their care plan. Another person was assessed as requiring bedrails; however there was no record of consent, a capacity assessment or best interest decision. A further person who was also recorded as lacking capacity. Their next of kin had signed to consent to their care and treatment; however they did not hold power of attorney for health and welfare which meant they did not have the authority to consent to this decision.

Most staff working in the home had a good understanding of the Mental Capacity Act 2005 (MCA). However one member of staff did not and told us that they required further training. Most staff we spoke with knew how to support people to make decisions and were clear about the procedures to follow where an individual lacked the capacity to consent to their care and treatment. We looked at staff training records that showed that staff had completed training in the MCA.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The manager had made some Deprivation of Liberty Safeguard (DoLS) applications for people living at the home. For example, when a person did not have the capacity to make a decision about where they lived and consent to the arrangement. The DoLS was to ensure they resided in a place of safety and received care in their best interest. The registered manager was aware of the recent supreme court ruling and explained that due to this they had applied for DoLS for most people living in the home. They also told us that 12 people living in the home was currently subject to a DoLs. However when we discussed this with staff they were unaware. This meant those people were at risk of unsafe or inappropriate care.

These shortfalls are breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we toured the home. We saw that the home was clear from trip hazards. The home had a secure garden for people to access should they wish. We saw that there was a large pond area in the garden that was surrounded by a small fence with a gate. The gate was not secure which could have posed a risk to people living in the home. We discussed this with the manager who told us that they would arrange for it to be appropriately secured. There was not always clear signage to the different areas of the home. For example, there was no signage to the lounges, dining area, toilets or gardens to support people with a cognitive impairment to orientate themselves. This was an area for improvement.

Staff attended supervision meetings. Staff told us that they found these useful. We looked at the supervision files for four members of staff who were on duty during our inspection and found that supervisions were not taking place in accordance with the provider's supervision policy, which stated that staff should receive supervision twice per year, observational supervision once per year and an annual appraisal. For example, one member of staff did not have any record of supervision since November 2013; another member of staff had not received supervision since February 2014. This was an area for improvement so staff received the support and supervision they needed.

The manager told us staff employed by the service received their training in house as the home formed part of a larger organisation. We looked at the staff training records which showed all staff received a comprehensive induction and ongoing training. We saw that training topics included infection control, moving and handling, fire, personal care, communication, dementia, and safeguarding adults. Staff told us they received the training they needed to help them understand and meet people's needs.

Requires improvement

Is the service effective?

People told us that the food in the home was good. Comments included, "The food is excellent." And "The food is brilliant, you can have a choice, the chef comes and asks me what I would like each day."

The home had a menu cycle. The assistant chef told us the menus were changed in response to feedback from people living in the home. We observed they took a high level of interest in people and chatted to everyone before and after their main meal to check what their choices were and if they had enjoyed their meal. People had meal choices on the menu at lunch time; however, they told us alternatives were offered to people who did not want or like the meal on the menu. The assistant chef was able to tell us about people's individual dietary needs and preferences. For example, how they catered for people with diabetes. However, they were unable to show us any records that contained people's dietary requirements. We discussed the importance of keeping up to date records with the assistant chef as this could potentially put people at risk. During the second day of our inspection the registered manager told us that they had located the records of people's dietary requirements.

We observed the meal service in the dining room at lunchtime. The tables were nicely set with table cloths, napkins and condiments. We saw people were offered a choice of cold drinks, fruit squash or water with their meals. The food was well presented and looked and smelled appetising. The meal service was pleasant and relaxed with people being given ample time to enjoy their food. We observed staff gently encouraging and supporting people to eat where necessary. People told us they enjoyed their lunch. One person said, "I had a lovely lunch."

Drinks and snacks were served mid-morning and in the afternoon. We observed staff offering people a choice of drinks throughout the day.

We looked at people's care plans, risk assessments had been carried out to check if people were at risk of malnutrition. The records showed that most people's weights were checked at either monthly or weekly intervals depending on the degree of risk. Records showed that people were referred to their GP or the dietician if there were any concerns about their nutritional intake. People had been prescribed dietary supplements to improve their nutritional intake and food/fluid charts were used to record and monitor what people were eating and drinking. This showed there were suitable arrangements in place to make sure people's dietary needs and preferences were catered for.

People were supported to maintain their health and had access to healthcare professionals when required. One person told us, "I see the GP when I need to; they came to see me yesterday as I have been in a bit of pain." During the inspection we noted various professionals such as the district nurse, and GP visiting people in the home. There were records of professional visits in all the care records we reviewed. We spoke with two visiting GPs who told us that they had no concerns. They told us that generally communication was good, appropriate referrals were made to the practice for support was made. This showed people's healthcare needs were being identified and they were receiving the input from healthcare professionals they required.

Requires improvement

Is the service caring?

Our findings

People who used the service and their families told us they were happy with the care and support they received. One person said, "The staff are very nice, you couldn't get better people, it's the thing that is most important to me. I've got my favourites." Another person told us, "The staff are okay, it works both ways." One relative told us, "I can't fault the care really; [person] needs a lot of support. Since [person] has come here I feel that have got [person] back again." Another relative commented, "The staff are wonderful, I come in regularly and feel welcomed."

Most of the rooms at the home were for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, to assist people to feel at home.

Staff interactions with people were considerate and the atmosphere within the service was welcoming, relaxed and calm. One person was distressed and staff reassured them and stayed with them until they were settled. When staff supported people to move they did so at their own pace and provided encouragement and support. Staff explained what they were going to do and also what the person needed to do to assist them.

Staff generally respected people's privacy and dignity and interacted with them in a positive manner. However, we observed occasions where people's dignity was compromised. We observed one occasion where a member of staff was supporting a person in an undignified manner. We saw that the manager recognised this and instructed the member of staff how to support the person appropriately. We observed another occasion where a member of maintenance staff sawing wood in a person's bedroom. We saw that the person was in their bed asleep and there was dust being created during the sawing. On a third occasion we saw a member of staff assisting a person with personal care in their bedroom, however they had not closed the bedroom door. We also saw that people's continence aids were left out in communal areas. The storage of these aids in communal areas did not promote people's dignity. One person raised a concern with us that the communal toilets did not have locks on them which meant there were times when their privacy and dignity may be compromised by others. We raised this with the manager who located the locks during the inspection and placed them back on the door.

These shortfalls are breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulation 10 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a good understanding of people's needs, some of their personal preferences and the way they liked to be cared for. For example, staff knew how one person presented, activities that they enjoyed and their preferences. People's life histories and personal preferences were recorded in their care plans.

Care files and other confidential information about people were kept in the main office. This ensured that people such as visitors and other people who used the service could not gain access to people's private information without staff being present.

Requires improvement

Is the service responsive?

Our findings

People who used the service told us that staff understood their needs well. One person told us, "I am well looked after." A visitor told us that they felt their relative received a good standard of care in the home.

People had an assessment of their needs completed prior to moving into the home, from which a plan of care was developed. However, people did not always receive support as described within their care plans. Some care plans were not updated as people's needs changed or were not in sufficient detail for staff to be able to follow them.

One person living in the home did not have a care plan in place. This placed people at risk of not receiving the care and treatment they needed. In other care plans we viewed, there was a lack of information about people's health and personal care needs to enable staff to deliver care in a person centred way. For example, one person who had epilepsy did not have an epilepsy care plan that contained sufficient details for staff to follow. It did not contain information how the person would present should they have an epileptic seizure. Some staff we spoke with were unaware that the person had epilepsy, which placed the person at risk of harm.

One person living in the home displayed behaviours that challenged others. We saw that the provider was completing a behavioural chart for this person. However, we saw that the chart was not fully completed or did not contain sufficient information of each incident in order to effectively identify and triggers or trends to inform the person's plan of care. We looked at the person's care plan and could not find a clear plan of care regarding management of these behaviours and instructions were sometimes contradictory. Failure to assess and plan for this person's needs placed the person at risk of being provided with inappropriate or unsafe care.

Care plans were not regularly reviewed which placed people at risk of inappropriate or unsafe care. One person's care plan had not been reviewed since June 2014. Another person's care plan had not been reviewed since August 2014.

Some people in the home were assessed as requiring hoisting. We found that their care plans did not specify the size of sling that should be used in order to hoist the person safely. We checked a selection of people's slings in their bedrooms and found that they were labelled with people's names, however that five slings that we looked at were in the wrong person's bedroom. This placed people at risk of harm.

These shortfalls are breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 now Regulations 9 (1)(2)(a)(b) and 12 (2) (a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who were assessed as being at risk of skin breakdown required regular repositioning in order to promote their wellbeing. We saw that there were repositioning charts in place to record this; however records showed that people were not always being repositioned in accordance with their care plan. For example, one person's care plan stated that they should be repositioned four hourly. Their records showed that on the 6 March 2015, they were only repositioned once in a 24 hour period.

Body maps were completed that recorded marks, bruises or injuries to people, however these were not regularly reviewed and updated to track the progress of healing. This placed people at risk of inappropriate care or treatment.

People's personal care preferences were recorded. The records we viewed did not always reflect these preferences. One person was recorded as liking a weekly bath; however their personal care records did not always reflect this. The care plans contained information about people's health and personal care needs and their likes and dislikes.

People's interests and hobbies had been recorded as part of the overall plan and records showed staff respected and promoted these. People we spoke with confirmed that the social and daily activities they undertook suited them and met their individual needs. One person told us that they enjoyed going out of the home when possible and staff confirmed that this took place. Another person who spent most of their time in their bedroom told us that this was their choice and staff respected this.

People and visitors said they felt able to raise any concerns about the service they received, among their comments were: "I'd speak to [manager] if I had a complaint". A visitor told us: "I've not had to complain, but I'd feel comfortable doing so." Arrangements were in place for people to inform the service of their concerns. There was a copy of the

Requires improvement

Is the service responsive?

provider's complaints procedure on display at the entrance of the home. The manager told us there had been one formal complaint since our last inspection that was in the process of being investigated.

People's needs were recognised and shared when they moved between services. The manager told us that when a person was admitted to hospital, staff provided information explaining why they required hospital support, a copy of their medicine administration record (MAR) and records of their care needs.

Requires improvement

Is the service well-led?

Our findings

A representative of the local authority contract monitoring team visited the home on 12 February 2015. They accompanied a social worker to investigate a safeguarding concern. They identified similar shortfalls to us, particularly in relation to poor recording keeping, medicines management and shortfalls in the monitoring of people's food and fluid intake. They had provided verbal feedback to the manager but this had not yet been acted on by the time we inspected.

There were regular audits in place that identified shortfalls but these were not consistently acted upon or completed at the frequency specified by the provider. For example, care plans were not reviewed and audited as prompted by the care planning documentation. In addition, the lounge soft furnishings were heavily soiled and needed replacing. This had identified in previous audits.

The provider's service manager told us following the inspection they would review all audit action plans at their monthly visits and would arrange to replace worn and damaged furnishings. They told us there was an action plan in place to address the shortfalls we identified. This included input the provider's clinical support manager to assist with reviews, audits and provide any additional training.

Records for people were not accurately maintained or monitored. We identified shortfalls in people's assessments, care plans and monitoring records. Repositioning records were not fully completed and body maps not consistently completed for people following falls or injuries. These records were not consistently reviewed. For example, body maps that were completed were not reviewed as prompted by the documentation to check whether people's injuries had healed.

Observations and feedback from people, staff, relatives and professionals showed us there was an open culture. Staff, relatives, health professionals and people were generally positive about the registered manager and they felt able to raise concerns and approach them. However, some staff told us they did not feel recognised by the provider for the hard work and commitment they showed to the people Templeman House.

We discussed ways in which people, staff and others were consulted with the registered manager. They told us that they held resident and relative meetings. However, due to poor attendance these no longer took place. They had not explored any different ways of consulting with people who lived at the home. Three relatives raised concerns about the laundry and clothing going missing but there was not any formal way of them feeding this information back to the registered manager.

These shortfalls in the governance of the home and record keeping were breaches of Regulations and 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 which corresponds to Regulation 17 (2)(a)(b)(c)(e)(f) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew how to raise concerns and were knowledgeable about the process of whistleblowing. They confirmed the registered manager, listened and acted on any concerns they raised.

The registered manager notified us about significant events and worked cooperatively with the local authority in relation to any safeguarding investigations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not sufficient numbers of staff deployed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: There were shortfalls in the assessments, planning, monitoring of and meeting people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: There were shortfalls in: The monitoring, managing and mitigating the risks to people. The safe management of medicines Assessing the risks of, preventing and controlling the spread of infection

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Care was not provided to people with the consent of relevant persons.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: Some people were not treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There were shortfalls in the governance of the home and record keeping.